Proposed Synopsis for Ph.D. in Psychiatric Social Work on

APPLICATION OF BRIEF PSYCHOSOCIAL INTERVENTION PACKAGE ON ELDERLY PEOPLE RESIDING IN OLD AGE FACILITIES TO ENHANCE THEIR QUALITY OF LIFE, COPING STRATEGIES AND WELL-BEING

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APPLICATION OF BRIEF PSYCHOSOCIAL INTERVENTION PACKAGE ON ELDERLY PEOPLE RESIDING IN OLD AGE FACILITIES TO ENHANCE THEIR QUALITY OF LIFE, COPING STRATEGIES AND WELLBEING

Old age is the closing period of the life span. It is a period when people 'move away' from previous more desirable periods or times of 'usefulness'. Old age is considered as a curse, being associated with deterioration of all physical, psychological factors, isolation from social, economic, and other activities. Socially, this stage was considered as the sum total of one's lived experiences. Hence, the society offered a space of respect to the old. In such a society, the aged were the repositories, transmitters, and sole authorities of wisdom and knowledge. All these provided a 'golden age' concept to this stage, old age is the closing period of the life span. It is a period when people 'move away' from previous more desirable periods or times of 'usefulness'. Old age is considered as a curse, being associated with deterioration of all physical, psychological factors, isolation from social, economic, and other activities. Socially, this stage was considered as the sum total of one's lived experiences. Hence, the society offered a space of respect to the old. In such a society, the aged were the repositories, transmitters, and sole authorities of wisdom and knowledge. All these provided a 'golden age' concept to this stage, old age

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State of the Art

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A person 65 years of age and older is considered an elderly person. The total number of youth and old people expressed as a percentage of the total population is used to compute the share of the dependent population. The ratio of the old population to the working-age (15–64) population is known as the elderly dependency rate. Differences in how regions and the topography of rural and urban communities are classified both within and between countries impact the comparability of data on the senior population. Due to the fact that the elderly are typically concentrated in a small number of areas within each country, these communities will

confront a variety of unique social and economic issues as a result of the aging population. In addition to having a significant impact on government and private spending on health care, education, and retirement, these demographic patterns also have broader consequences for economic growth and welfare. The population percentage is used to measure this metric.

One in six people on the earth will be 60 years of age or older by 2030. At that point, the proportion of the global population that is 60 years of age or older will rise from one billion in 2020 to 1.4 billion. By 2050, the number of people in the world who are 60 years of age or older will have doubled to 2.1 billion. Those who are 80 years of age or older are predicted to triple between 2020 and 2050, reaching 426 million.

Ageing is the biological consequence of a multitude of molecular and cellular damage that accumulates over time. This causes one's physical and mental abilities to gradually decline, their chance of illness to rise, and eventually their demise. These changes are only tangentially correlated with an individual's age in years, and they are neither linear nor consistent. The variety observed in later life is not coincidental. Aside from biological changes, aging is frequently linked to other life transitions including retirement, moving to a more suitable home, and losing friends and companions.

Chronic obstructive pulmonary disease, diabetes, depression, dementia, back and neck discomfort, cataracts, refractive errors, hearing loss, and osteoarthritis are common illnesses in older adults. People are more prone to have multiple ailments at once as they get older.

The advent of multiple complex health states collectively referred to as geriatric syndromes is another characteristic of older age. They include weakness, confusion, stumbles, urine incontinence, and pressure ulcers, and are frequently the result of several underlying problems. (World Health Organization, 2022)

“Elderly or old age consists of ages nearing or surpassing the average lifespan of human beings. The boundary of old age cannot be defined exactly because it does not have the same meaning in all societies. In the Maintenance and Welfare of Parents and Senior Citizens Act, 2007, senior citizen means any person being a citizen of India, who has attained the age of 60 years or above” (Jeyalakshmi et al., 2011).

Care home or old age home is a home environment primarily for those elderly persons who are unable to stay with family members due to various reasons. It is an alternative shelter where the older individuals live, can share their feelings and experiences with each other. It is an institutional type of setup and the people live here according to some rules and regulations. Community dwelling elders are the elderly individuals who reside in the community with their family members. Aruna Dubey, et al concluded in a study that the general feelings of the elderly

women living in the families were better than that of the women living in the institutions. Better social relations were maintained by the family dwellers because they had regular interaction, expressions of feelings and support from the family.

Factors influencing healthy ageing

Opportunities for elderly people and their families as well as for society at large arise from living longer. The opportunity to pursue new endeavors, such as additional schooling, a new career, or a long-neglected interest, is presented by additional years. In many more ways, older people support their families and communities. However, one thing largely determines the scope of these opportunities and contributions: health.

Research indicates that the percentage of life in excellent health has been rather stable, indicating that the extra years are spent in poor health. People's ability to perform the things they cherish in life will not change much from that of a younger person if they can live these extra years in excellent health and in a supportive environment. The effects on elderly persons and society as a whole will be more detrimental if these extra years are mostly attributed to reductions in physical and mental ability.

While there is some genetic variation in the health of older adults, the majority of variances in older adults' conditions are caused by their physical and social settings, which include their houses, neighborhoods, and communities, as well as their personal traits, which include their sex, ethnicity, or financial position. In addition to their inherent traits, the surroundings that individuals grow up in even as developing fetuses have a lasting impact on how they mature.

The social and physical environments have the power to directly impact health, as well as to influence opportunities, decisions, and health-related behavior through obstacles or rewards. A balanced diet, regular exercise, and abstaining from tobacco use are just a few of the healthy habits that can help lower the risk of non-communicable diseases, enhance mental and physical abilities, and postpone the need for treatment.

In addition to enabling people to pursue what matters to them, supportive social and physical surroundings also help people maintain their ability. Examples of supportive surroundings include areas that are convenient to walk about, have safe and accessible public transportation, and buildings. When creating a public health response to ageing, it's critical to take into account strategies that may support recovery, adaptation, and psychological development in addition to those that address the losses that come with getting older.

The variety observed in later life is not coincidental. People's social and physical environments, as well as how these affect their opportunities and health-related behaviors, are major

contributing factors. Personal traits like the family we were born into, our sex, and our race distort our relationship with our environments, which causes disparities in health.

It's common to think that elderly people are weak, dependent, and a drain on society. These and other ageist beliefs need to be addressed by public health professionals and society at large because they can result in discrimination, have an impact on how policies are created, and limit the possibilities that older people have to age well.

The lives of older people are being affected both directly and indirectly by factors such as globalization, migration, urbanization, technology advancements (such as those in transportation and communication), and shifting gender norms. A public health response needs to assess these present and future trends and adjust policy as necessary.

An important resource for any society is the elderly. Growing older is a normal occurrence that brings both benefits and challenges. As per the 2011 Census, 104 million Indians are above 60 years of age, making up 8.6% of the country's overall population. The elderly (60+) are more likely to be female than male.

Seniors are more likely to be neglected and lonely as a result of longer lifespans, fewer combined families, and a deteriorating social fabric. It is advised to lead a healthy lifestyle devoid of alcohol, tobacco, and other habit-forming substances, as well as regular exercise and a balanced diet. As one ages, a positive outlook and mental health support a higher quality of life.

The legal basis for addressing the needs of seniors is provided by the Government of India's National Policy on Older Persons 1999, Maintenance and Welfare of Parents and Senior Citizens Act, 2007, and National Policy for Senior Citizens 2011. Elderly patients receive specialized healthcare in primary care settings through the National project for Health Care of the Elderly and Health and Wellness Centers under the Ayushman Bharat project. (*Ageing and Health India*, n.d.)

Over the past few years, super-agers have emerged as a new subset of elderly citizens according to medical science. The phrase describes those who are in their 70s and 80s but possess the mental or physical faculties of those who are decades younger. Due to the world's growing aging population, 34 countries are predicted to have more than 20% of their population over 65 by 2030. Long-term research on "super agers" from throughout the world have recently examined the routines, behaviors, and health markers of people under 90 years old. In addition to those suffering from dementia and cognitive decline, researchers are also interested in healthy older adults. While studies are being conducted on general health, family history, and psychosocial factors, it is imperative to also focus on improving and targeting integrated-care

approaches that are community-based, tailored to the requirements of older adults, and have efficient coordination and long-term care systems. Every society can attest to this, but those with super- and ageing populations in particular.

As people age, their mental health is influenced by their physical and social surroundings as well as the accumulated effects of their past experiences and particular age-related stressors. Psychological distress can be caused by a variety of factors, including considerable loss of intrinsic capacity, exposure to adversity, and a deterioration in functional ability.

Adverse occurrences like bereavement, income declines, or a diminished feeling of purpose after retirement are more common among older persons. Ageism affects a lot of older folks despite their numerous contributions to society, and it can have a negative impact. About 25% of older adults experience social isolation and loneliness, which is a major risk factor for mental health issues later in life. Elder abuse encompasses various forms of maltreatment such as physical, verbal, psychological, sexual, or financial abuse, in addition to neglect. Abuse, frequently by their own caregivers, affects one in six older individuals. Abuse against senior citizens can result in major repercussions, including anxiety and sadness.

Many elderly people provide care for spouses who have long-term medical issues, like dementia. The carer's mental health may be impacted by the caregiving duties, which can be extremely demanding. Because of their extreme living circumstances, poor physical health, or lack of access to high-quality support and services, certain older persons are more likely to experience anxiety and despair. This include senior citizens residing in humanitarian environments as well as those dealing with long-term medical ailments (such cancer, heart disease, or stroke), neurological disorders (like dementia), or drug abuse issues.

Symptoms of mental disorders in older adults?

- Noticeable changes in mood, energy level, or appetite
- Feeling flat or having trouble feeling positive emotions
- Difficulty sleeping or sleeping too much
- Difficulty concentrating, feeling restless, or on edge
- Increased worry or feeling stressed
- Anger, irritability, or aggressiveness
- Ongoing headaches, digestive issues, or pain
- Misuse of alcohol or drugs
- Sadness or hopelessness
- Thoughts of death or suicide or suicide attempts

- Engaging in high-risk activities
- Obsessive thinking or compulsive behavior
- Thoughts or behaviors that interfere with work, family, or social life
- Engaging in thinking or behavior that is concerning to others
- Seeing, hearing, and feeling things that other people do not see, hear, or feel

Older people, through their socio-economic contribution, caregiving and passage of traditions and cultural values, are an asset for the society. Nevertheless, old age in itself can often be a very vulnerable phase, as the physical and emotional health in later life declines.

There have been an increase within the existence of the aged people in India in the past and the country is regarded of having the second largest aged population in the world. Family is considered to be the main support and the security for the elderly individuals. In urban and rural areas, people who are educated, wealthy and possess strong beliefs, values and norms regard elderly individuals and pay them great deal of respect, their needs are adequately taken care of and they are consulted when any important decisions are to be made, hence the elderly individuals also take pleasure and satisfaction in living with their children and grandchildren. On the other hand, underprivileged, poverty stricken and deprived individuals and families who do not possess the resources, finances and other means to take care of the elderly consider them as a burden and send them to old age homes where their needs can be adequately taken care of. Old age homes are the places that are established by some of the social organizations where elderly people take refuge. In old age homes, there have been provision of all the basic facilities and amenities; the elderly individuals who are ill or need special care, even their needs are adequately taken care of. The main problems that the elderly individuals face in old age homes are in personal and social adjustment.

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Old age home (alternative shelter for the elderly): The home environments primarily for those elderly persons who are unable to stay with family members due to any reasons. It is an alternative shelter where elderly persons can share their feeling, liking, experiences with each other staying at this type of settlement. They live in an institutional setup according to some rule and regulations.

Often older adults go to old age homes as they give them security and medical attention. They may experience loneliness but at the same time feel a sense of independence. On the other hand, some of them are forced to move to an old age home because they have experienced lack of emotional support, verbal and at times physical abuse, neglect and disrespect from their children. But, often in spite of this, they seem to prefer to be living in the comfort of their own home with their children and grandchildren (Kumar et al., 2012; HelpAge India, 2013; HelpAge India, 2014).

Older adults living in old age homes face problems of adjustment with tight and rigid schedules; total or near-total separation from their family, friends and society; anxiety over entrusting oneself to a new environment; diminished physical ability and close and frequent encounters with death and ailments in the institution. For many of them social support is almost absent and this leaves older adults with the feeling that he or she does not belong, is not loved or cared for, esteemed or valued (Kumar et al., 2012). These and other factors make older adults increasingly vulnerable to mental health problems and their undesirable effects (HelpAge India, 2013).

Older adults have unpleasant experiences as they not only have to deal with change in their living environment but also have to get used to changes in daily life routines and social and support networks. They feel the loss of family and a sense of loneliness due to the loss of social interactions. They also feel a sense of powerlessness and their perceptions and fears had adverse effects on their adapting and settling into a new environment. Often they join the old age home because of the loss of a spouse, deterioration in health and the inability to look after oneself due to physical illness and disability, which leads to increased financial problems (Salarvand et al., 2008; Sigaroudi et al., 2013). Older adults take time to be acclimatised to a new environment when they relocate to an institution, which they have to call home. They take time to adjust to and transform their perspective of themselves and their environment; they

actively reflect on their life experiences and the struggles they experience and cope with, as this helps them to create a meaningful existence within the context of a care home. They eventually get completely involved in the life they are supposed to live. In addition to this, the holistic needs of older adults such as social, mental, financial, spiritual and physical needs are to be considered in order to promote a purposive and meaningful life for them (Stone, 2009; de Guzman, 2012).

With increased frailty and deteriorating health comes the fear of falling which seems to be a common complaint with older adults. In order to cope effectively, they learn to discipline their daily lives by learning to accept and live with the challenges of their vulnerable and deteriorating physical condition and the loss of control at different levels such as when they fall, from incontinence and from the stigma of facing an embarrassing situation. Older adults try to be as independent as possible but are also dependent on community care. They cope with their fear of falling by strengthening their will (Mahler and Sarvima¨ki, 2012).

The much prevalent joint family system of India has been changed in recent times and family size is reducing, whereas aging population is continuously increasing. Changes in the traditional family structure have led to the need of community care for aged parents and the emergence of old age homes in India. Older adults often join the old age homes as they give them security and medical attention. Other common reasons to chose for an old age home stay in elderly include the loss of a spouse, deterioration in health and the inability to look after oneself due to physical and financial reasons. Inspite of all these reasons with Indian elderly too, they want to live with comfort in their own home with their children and grand children. In India today, the ‘old age home’ is no longer a western concept. Though, no concrete figure is available but the numbers of old age homes in India are increasing and is estimated to be more than 1000. Old age homes are not considered as western concept in today's Indian society. Indeed, some old age homes are making sincere efforts to uphold the needs, desires and values of elderly.

No stage of life is smooth and has its own problems, but those of old age are particularly more difficult due to reduced physical and mental capability to cope with them. Old age population is more vulnerable to health-related problems including mental health problems.

For older adults living in old age homes, this vulnerability to mental health problems is further increased as they face problems of adjustment with rigid schedules; lack of social support, separation from family, anxiety related to a new environment and close and frequent encounters with death and ailments in the institution. In addition they also feel a sense of

powerlessness, decreased self esteem and emotional and psychological distress. (Maheshwari et al., 2021).

Quality of life (QOL)

Quality of life is a complex concept that encompasses objective and subjective dimensions such as food housing the opportunity to study health and perceptions about them (Carpio, Pachecho, Flores & Canales, 2000).

Diener (1984) Has defined quality of life as a subjective view of the extent to which happiness and satisfaction have been achieved or as a sense of personal subjective view that has also been considered closely related to certain biological economic psychological and social factors.

Quality of life (QOL) is a term that is used in many studies, mainly in the health care field. QOL is a broad multidimensional and dynamic concept that affects performance of the individual in physical, psychological, social, and spiritual aspects of life. World Health Organization (WHO) describes QOL as "the individual's perception of their life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns". QOL has become an area of increasing importance to the area of maternal and child health. Women's perception of their health-related quality of life is an essential measure of the quality and effectiveness of maternal and child health interventions.

Most definition quality of life considers-

- Physical health status
- Functional ability
- Psychological status and wellbeing
- Social interaction and
- Economic status (Spiker, 1990)

The components of quality of life

Quality of life has both subjective component that is wellbeing, life satisfaction and objective component- functioning and social roles.

According to Lehman's model quality of life is ultimately a subjective matter, reflected insense of global well-being.

The experience of general wellbeing is viewed as being a product of three types of variables:

- Personal characteristics
- Objective quality of life in various life domain
- Subjective quality of life in the same domain.

Objective Indicators of Quality of Life-

The earliest approaches to the measurement of quality of life explode social indicators objective indicators of quality of life are assessed by comparing the individuals to a larger population on a variety of social indicators.

Examples of social indicators include things such as employment housing status income the size and nature of one social network opportunities for laser and access to certain commonly accepted social goods (TV, radio, car etc.) (Holloway and Carson, 2002).

Objective indicators typically have more apple because they are tangible reflect accepted norms of function and lifestyle and more directly address conditions that can be manipulated in service programs (Lehman, 1983).

However there major disadvantages is that they came little about how individual fields about his or her life therefore potential a meeting in the visual input from treatment of program planning.

Subjective Indicators of Quality of Life-

An alternative view of quality of life is that in essence it relates to "a person's sense of well being his satisfaction with life or happiness or unhappiness" (Baker et al 1982).

Typically, this is conceptualized as a global measure of well being or life satisfaction Holloway and Carson, 2002) but has also been broken down into satisfaction within specific life domains.

Lehmn undertook ground breaking research that demonstrated the capacity of people with serious mental illness to report there subjective and objective quality of life and presented a model that brought these constructs together. He maintained that subjective quality of life implies a relatively stables save assessment of life conditions and is influenced by expectations, prior experience, and perceptions of current conditions (Lehman, 1983)

Similarly, Frisch (1983) describe subjective quality of life as composed of two parts. The first component involves positive effect. The second component is cognitive in which an individual needs and wishes have been fulfilled, and relates this to personal satisfaction.

Lehman (1983) has argued that rather than engage In theoretical debates about the validity of the two types of quality of life one should recognize that they do indeed measure different and complementary aspects of an individual's life experience.

Factors of Quality of life and their classification-

Authors analyzing quality of life agree that it is determined by internal and external environment (Cummings, 1996; Hagerty, 2001). Levels of development of a country, political

and socioeconomic environment allows people to leave well and seek quality of life. Whether individuals are able to make use of the internal environment, to seek higher physical, personal development, material, and social welding, and it is determined by the internal environment. On this basis two groups of factors determining quality of life may be identified.

The first group of factors include both the factors, which may not be regulated by public policy measures (climate conditions and their indicators, geographical position of the country) and those which are affected by public policy actions (political stability, corruption, economic growth, social security, etc.) The second group of factors consists of those factors which may be to or significance extent controlled by a person, as a holder of rights and freedom himself (health conditions, educational achievement, family, leisure etc.)

B. Lindstorm 1983 suggests classifying factors determining quality of life into more specific categories, depending on what sphere they represent: global, external, interpersonal or personal.

The main group of factors affecting the quality of life and identified various fields of science, are the following:

- *Physical well-being (health conditions, functional conditions)*
- *Material well-being*
- *Social well-being*

A group of factors, **physical wellbeing**, is one of the key elements in most quality of life studies (Fence and Perry, 1995), physical wellbeing includes such factors as health conditions, ability to move and work, and personal security. In clinical practice, this group of factors encompasses physical conditions (pain and unpleasant sensation, energy and fatigue, sleep and rest) and functional conditions (individual's physical capacity, community health, emotional condition). The latter factors describes individual's ability to perform daily tasks. R. L Schalock (2004) suggests a wider understanding of physical well being and supplements health factors (physical condition, nutrition, activity) with leisure – rest, entertainment, and hobbies.

From the economic point of view, another group of factors affecting quality of life is important. It is material wellbeing. When analyzing it as a group of external environmental factors of quality of life, a macroeconomic situation of a country (economic activity, macroeconomic stability) and the role of the state in economic life of the country as assessed. On the other hand, on the level of individual's quality of life, material wellbeing includes such factors as a financial situation (income and accumulated wealth), living/ housing conditions, and employment (Easterlin, 1995, Schalok, 2004). It is interesting that according to the results of

studies conducted by psychologists (Kahneman et al., 1999) and economist (Layard 2005), relationship between average happiness and average income is not direct – after a certain level of income is reached, no further gain in quality of life is observed.

Thus, the importance of material well-being, as an internal factor affecting quality of life, decreases. To explain this, British economist R. Layard (2005, 2007) uses the principles of habit and rivalry. First, people quickly get used to higher income, thus it does not provide such a great satisfaction, as one might expect. Also, people's perception about minimum income, which would be sufficient for subsistence, is constantly changing. Second, people tend to compare themselves with their social environment- family, neighbors, friends, colleagues. Income and accumulated wealth is no exception.

According to happiness researcher, economist J. S. Duesenberry (1949), it is not only the absolute income, which is important to the person, but also the relative one in comparison to other members of the society. When everybody's income is growing less quickly than that of the relative leader of the group.

Social well-being constitutes probably the largest group of factors affecting quality of life and is gaining prominence in quality of life research. Such factors as income and material assets are pushed aside by social wellbeing factors, bringing family, social life, and leisure to the center of the stage. The drive of the industrial consumers society to earn as much money as possible reduced amount of free time and disrupted work- rest balance, hence the importance of leisure and time with a family for quality of life had grown.

To summarize, a wide range of quality of life factors and different their classifications suggested by scientific literature creates a great confusion in quality of life research. The authors believe that measurement of quality of life should take into account multidimensionality of the concept of quality of life. To increase validity and reliability of quality of life research results, quality of life should be measured using systematic approach characterized by the identification of factors and their groups and determination of relationships among them.

The elderly represent a population group that requires a specific and integral approach that promotes its wellbeing and health. There are contextual factors experience during this life stage, such as the generation of diseases, which can influence negatively central aspects of life. One of the constructs that could be affected by these factors is the Quality of Life (QOL). The interaction between the contextual variables and QOL is mediated by the Coping Strategies (CS) that the individual applies to cope with the environmental challenges.

The universal process of ageing has a physical and psychological impact on every human being. Although the process of ageing is thought to begin at conception, it actually begins when a person's body begins to function less effectively, which impairs their capacity to respond to stimuli and increases the risk of contracting age-related disorders. It is also noticed that the majority of elderly people rate their QOL favourably based on social ties, dependence, health, material security, and social comparisons. A high QOL may be influenced by resilience and adaptation. Quality of life sparked a rise in academic interest after World War II, as socioeconomic discrepancies were becoming more generally acknowledged. This served as the catalyst for studies on social indicators, which led to studies on subjective well-being and quality of life. The QOL theory presented here was built on Abraham Maslow's theory of human development. It is argued that members of advanced societies are mainly focused on achieving higher-order needs (social, esteem, and self-actualization needs), whereas those of less advanced societies placed emphasis on achieving lower-order needs (biological and safety needs). The hierarchy of need satisfaction levels of the majority of the population in a given society is used to explain QOL. A society's quality of life rises in direct proportion to how well its majority's needs are met. Institutions are basically formed to meet QOL and requirements of a society and its members. Productive, maintenance, managerial/political, and adaptive institutions are expected to meet human needs and work towards QOL. Each of these types of societal institutions has a hierarchical dimension. It is thought that shifts in the hierarchies of these societal institutions go hand in hand with progressive advances in QOL.

Wellbeing

Subjective well-being (SWB) refers to how people experience the quality of their lives and includes both emotional reactions and cognitive judgements (Diener 1984). Psychologists have defined happiness as a combination of life satisfaction and the relative frequency of positive and negative affect (Diener et al, 1991). Subjective wellbeing therefore encompasses moods and emotions as well as evaluations of one’s satisfaction with general and specific areas of one’s life (Diener et al, 1999). Subjective wellbeing tends to be stable over time and is strongly related to personality traits. (Steel et al, 2008). There is evidence that health and SWB may mutually influence each other, as good health tends to be associated with greater happiness (Okun et al, 1984) and a number of studies have found that positive emotions and optimism can have a beneficial influence on health. (Diener & Chan 1984).

Subjective wellbeing is made up of cognitive (life satisfaction and positive functioning) and emotional (positive and negative affect) components. Subjective wellbeing is a

multidimensional concept broadly considered to have cognitive (life satisfaction and positive functioning) and emotional (positive and negative affect) components that are subjective for the individual and relative to social norms and values.

Subjective well-being (SWB) refers to how people experience and evaluate their lives and specific domains and activities in their lives. Economists, psychologists, and sociologists have found a number of distinct components of SWB to coexist but which are not entirely independent they do overlap. These measurement constructs may be thought of in terms of a continuum, with essentially real-time assessments of experience, emotional state, or sensations at one end (associated with the shortest time unit) and overall evaluations of life satisfaction, purpose, or suffering at the other end (the longest reference periods or no particular reference period).

Subjective well-being (SWB), also known as self-reported well-being, refers to how people experience and evaluate different aspects of their lives. It is often used to measure mental health and happiness, and it can be an important predictor of individual health, wellness, and longevity.

It has become a useful measure of societal health. In addition to providing a way to assess how people feel about their lives, it also offers insights that can be used to guide public health, economic, and social policies. Policymakers utilize assessments of subjective well-being to gauge the health of societies and measure the impact of social policies.

World Health Organization highlighted the need to set wellbeing targets as part of European Health 2020 policy and the Department of Health England have stated that wellbeing is a shared government objective. Maternity care policy recognizes that most women are well and that promoting emotional wellbeing is as important as supporting physical health. While mental health problems are increasingly screened, it is important to broaden the assessment of psychological status during pregnancy in order to take action to optimize wellbeing at this time. Subjective well-being (SWB) has a protective role in mental health maintenance and is prone to change during short stressful moments, such as pregnancy, child birth etc.

Components of Subjective well-being:

Diener et al argued that the various components of SWB represent distinct constructs that need to be understand separately, even though they are closely related. Hence SWB may be considered “a general area of scientific interest rather than a single specific construct” (Diener et al. 1999). Due to specific focus on the subjective aspects of wellbeing, definitions of SWB typically exclude objective conditions such as material conditions or health, although these can

influence ratings of SWB (Diener 1984). Definitions of SWB therefore focus on how a person evaluates their own life, including emotional experiences of pleasure versus pain in response to specific events and cognitive evaluations of what a person considers a good life (Diener, 2000). Components of SWB relating to affect include high positive affect (experiencing pleasant emotional moods) and low negative affects (experiencing unpleasant, distressing emotions and moods), as well as "overall affect" or "hedonic balance", defined as the overall equilibrium between positive and negative affect, and usually measured as the difference between the two (Steel et al, 2008). High positive affect and low negative affect are often highly correlated, but not always (Diener et al, 2000). Subjective wellbeing include positive and negative affect, happiness and life satisfaction. Positive psychology is particularly concerned with the study of SWB (Diener, 2000).

Positive Psychology:

The study of SWB is a central concern of positive psychology (Lyubomirsky, Sonja, 2001). Positive psychology was founded by Seligman and Csikszentmihalyi (2000), who identified that psychology is not just the study of pathology, weakness and damage, but it is also the study of strength and virtue (Seligman et al, 2000). Researchers in positive psychology have pointed out that in almost every culture studied the pursuit of happiness, is regarded as one of the most valued goals in life. Understanding individual differences in SWB is of key interest in positive psychology, particularly the issue of why some people are happier than others. Some people continue to be happy in the face of adversity whereas others are chronically unhappy all the best of times. Additionally, positive psychology has investigated how people might improve their level of SWB and maintain these improvements over the longer term, rather than returning to baseline (Lyubomirsky, Sonja, 2001). Lyubomirsky, 2001 argued that SWB is influenced by a combination of personality/ genetics (studies have found that genetic influences usually account for 35- 50% of the variance in happiness measures), external circumstances, and activities that affect SWB (Roysamb et al, 2002). She argued that changing one's external circumstances tends to have only temporary effect on SWB, whereas engaging in activities (mental and/or physical) tat enhance SWB can be lead to more lasting improvements in SWB (Lyubomirsky, Sonja, 2001).

Subjective Well-Being and Health:

There are substantial positive associations between health and SWB so that people who rate their general health as "good" or "excellent" tend to experience better SWB compared to those

who rate their health as “fair” or “poor”. A meta-analysis found that self-ratings of general health were more strongly related to SWB than physician rating of health (Okun et al, 1984). The relationship between health and SWB may be bidirectional. There is evidence that good subjective wellbeing contributes to better health (Diener & Chan, 1984). A review of longitudinal studies found that measures of baseline subjective wellbeing constructs such as optimism and positive affects predicted longer term health status and mortality. Conversely, a number of studies found that baseline depression predicted poorer longer term health status and mortality. Baseline health may well have a casual influence on subjective wellbeing so causality is difficult to establish. A number of studies found that positive emotions and optimism had beneficial impact on cardiovascular health and on immune functioning. Changes in mode are also known to be associated with changes in immune and cardiovascular response. There is evidence that interventions that are successful in improving subjective will be can have beneficial effects on aspects of health for example meditation and relaxation training have been found to increase positive effect and to reduce blood pressure the effect of specific types of subjective will be is not enterally clear for example how do you Rebel the effects of mood and emotions on health are remains unclear.

Psychological wellbeing and health are closely linked at older ages. Three aspects of psychological wellbeing can be distinguished: evaluative wellbeing (or life satisfaction), hedonic wellbeing (feelings of happiness, sadness, etc), and eudemonic wellbeing (sense of purpose and meaning in life). The Gallup World Poll, an ongoing survey in more than 160 countries, shows a U-shaped relationship between evaluative wellbeing and age in rich, English-speaking countries, with the lowest levels of wellbeing around ages 45-54. But this pattern is not universal: for example, respondents from the former Soviet Union and Eastern Europe show a large progressive decline in wellbeing with age; Latin America also shows falling wellbeing with age, while wellbeing in sub-Saharan Africa shows little change with age. The relationship between physical health and subjective wellbeing is bidirectional. Older people suffering from illnesses such as coronary heart disease, arthritis and chronic lung disease show both raised levels of depressed mood and impaired hedonic and eudemonic wellbeing. Wellbeing may also have a protective role in health maintenance.

Psychological wellbeing and health are closely related, and the link may become more important at older ages, if only because the prevalence of chronic illness increases with advancing age. As life expectancy increases and treatments for life-threatening disease become more effective, the issue of maintaining wellbeing at advanced ages is growing in importance. Studies of older people indicate that evaluations of quality of life are affected by the person’s

state of health, but the frequent finding that average self-reported life evaluation in the population increases with age suggests that psychological wellbeing is affected by many factors other than health. These include material conditions, social and family relationships, social roles and activities, factors that also change with age. There is a growing research literature suggesting that psychological wellbeing may even be a protective factor in health, reducing the risk of chronic physical illness and promoting longevity. It has also been argued that psychological wellbeing should be addressed in measures of health valuation, and be considered in health care resource allocation.

Measurement of psychological wellbeing

Within the construct of psychological wellbeing, there are at least three different approaches, each capturing a different aspect: life evaluation, hedonic wellbeing, and eudemonic wellbeing. (1) Life evaluation refers to peoples' thoughts about the quality or goodness of their lives, their overall life satisfaction or sometimes how happy they are with their lives. Measurement uses such questions as the Cantril Ladder, wherein individuals are asked to place themselves on an 11-step ladder with 'worst possible life' representing the lowest rung and 'best possible life' the top rung. Instructions are usually vague about how the evaluation should be made. (2) Hedonic wellbeing refers to everyday feelings or moods such as experienced happiness (the mood, not the evaluation of life), sadness, anger, and stress, and is measured by asking respondents to rate their experience of several affect adjectives such as happy, sad, and angry. It is important to note that the negative adjectives are not simply the opposite of positive indicators of wellbeing – they carry unique information about peoples' emotional states; in other words, hedonic wellbeing is not a simple unipolar dimension, but is composed of at least two modestly associated dimensions. Therefore, positive and negative adjectives are required for a reasonable assessment of hedonic wellbeing. (3) Eudemonic wellbeing focuses on judgments about the meaning and purpose of one's life; because the construct is more diverse, several questionnaires tapping various aspects of meaning have been developed. An important distinction among the types of wellbeing is the level of cognitive processing required: feelings can be reported relatively directly, whereas life evaluations and meaning questions are likely to demand considerable reflection including aggregation over time and comparison with self-selected standards (e.g., my life compared to what, when, or whom?).

There has been a revolution in the assessment of hedonic wellbeing over the past decade. Conventionally, measures of hedonic wellbeing ask the respondent to reflect over the previous week or month which given the inability of people to remember their affective states is likely

to induce an evaluative, not a hedonic response. The new approaches greatly reduce this problem by having individuals report about relatively brief and recent periods and thus more directly taps emotional states without the overlay of evaluation. Reporting periods for such assessments may range from the immediate moment through longer periods such as a day; to establish more reliable hedonic indices, multiple momentary ratings are usually averaged. Ecological momentary assessment whereby subjects are randomly prompted to report affect has many desirable features, but can be closely replicated by the Day Reconstruction Method in which people remember episodes from the previous day, and associated feelings with them or even, for large sample averages, by asking people about their feelings for the entire previous day (the procedure used in the Gallup-Healthways interview).

The notion that impaired psychological wellbeing is associated with increased risk of physical illness is not new, since there is an established research literature linking depression and life stress with premature mortality, coronary heart disease (CHD), diabetes, disability and other chronic conditions. What is new is the possibility that positive, psychological wellbeing is a protective factor. Prospective epidemiological studies suggest that positive life evaluations and hedonic states such as happiness predict lower future mortality and morbidity. (Chida Y, Steptoe A., 2008)

Older adults with better mental health can have optimistic attitudes that enable them to cope effectively with life's adversities and challenges, resulting in higher well-being. Mental health helps to enhance the coping capacity and adaptability of older people to confront problems, thus increasing their subjective well-being. The older adults' level of subjective well-being can be positively predicted by their mental health. Mental health mediates the association between physical health and SWB of older individuals, which implies that physical health can indirectly influence older individuals' subjective well-being through mental health. A deterioration in an older person's physical health can sometimes be followed by a fall in their mental health, and that leads to lower well-being. Physical health can substantially impact the mental health of older individuals, and disability, chronic disease, insomnia, and other physical functions decreases in physical function can contribute to low self-esteem, anxiety, depression, and other mental issues in older individuals. (Zhang & Sun, 2024).

Coping Strategies

Coping strategies are behavioral and cognitive tactics used to manage crises, conditions, and demands that are appraised as distressing. An important development in coping research was the creation of Robert Folkman and Susan Lazarus' Ways of Coping scale. This scale was

devised to assess the extent to which one uses one of two general types of coping. Problem-focused coping is directed at problem solving or taking action to change the source of the stress. Emotion-focused coping, in contrast, focuses on reducing or managing the emotional distress that results from the crisis.

Coping usually involves adjusting to or tolerating negative events or realities while you try to keep your positive self-image and emotional equilibrium. Coping occurs in the context of life changes that are perceived to be stressful. Psychological stress is usually associated with negative life changes, such as losing a job or loved one. However, all changes require some sort of adaptation. Even positive changes such as getting married or having a child can be stressful.

Changes are stressful because changes require us to adjust and to adapt. Experiencing too many changes within a brief time period often creates the idea that we aren't in control of events. This perception contributes to low self-esteem and may even contribute to the development of anxiety or depression. In some cases, physical illnesses may develop or get worse when a person's capacity to adapt to change is overwhelmed by too much change.

Coping involves adjusting to unusual demands, or stressors. This requires giving a greater effort and using greater energy than what's needed in the daily routines of life. Prolonged mobilization of effort can contribute to elevated levels of stress-related hormones and to eventual physical breakdown and illness.

Stressors that require coping may be acute, like moving to a new home or experiencing the onset of marriage problems. Stressors also occur that are of longer duration, such as chronic pain, chronic illness or long-lasting financial problems.

The effect of many acute stressors that come within a relatively brief period of time may be cumulative and profound. Those who experience a marital separation, the death of an aging parent and a change in job within a brief period of time may struggle to maintain their physical and emotional health.

What are some common coping strategies?

Some common coping mechanisms may challenge you to:

- Lower your expectations.
- Ask others to help or assist you.
- Take responsibility for the situation.
- Engage in problem solving.
- Maintain emotionally supportive relationships.

- Maintain emotional composure or alternatively, expressing distressing emotions.
- Challenge previously held beliefs that are no longer adaptive.
- Directly attempt to change the source of stress.
- Distance yourself from the source of stress.
- View the problem through a religious perspective.

Experts agree that coping is a process rather than an event. People may alternate between several of the above coping strategies in order to cope with a stressful event. People differ in particular styles of coping or prefer to use certain coping strategies over others. These differences in coping styles usually reflect differences in personality. Rigidity in coping is less likely to help than is flexibility in coping — being able to fit the most appropriate coping strategy to the demands of different situations.

However, some situations that require coping are likely to elicit (bring out) similar coping responses from most people. For example, work-related stressors are more likely to elicit problem-solving strategies. Stressors that are perceived to be changeable are more likely to elicit problem-solving strategies while stressors perceived to be unchangeable are more likely to elicit social support seeking and emotion-focused strategies.

Coping, in the model by Lazarus and Folkman, is defined as the cognitive and behavioral actions and strategies used when faced with stressful situations arising from internal or external demands which are perceived as overburdening the personal resources of the individual5.Coping is subdivided into two groups according to the function it performs: emotion-focused coping and problem-focused coping.

Coping for elderly persons is different from coping for people of other age groups, as stressors also change with age. While young adults experience more stress in areas related to work, their finances, home maintenance, their personal life, family, and friends; the elderly tend to experience stress related to the limitations of aging.

Elderly people have multiple issues related to coping. The stress-causing factors in their life include health, lowering energy level, poor immunity, decreased cognitive abilities, poor social support, feeling of loneliness, insecurity to life, emotional distress, and so on (Graham & Christian et al., 2006). They need consistent coping mechanism to be used in daily life. They have the rigidity to accept new ideas and learn new ways of living is another issue they need coping to handle the routine stress of modern life (Rubio & Dumitrache, et al., 2016). Kuria (2012) suggested that elder people prefer to use adaptive and active strategies in stressful conditions.

Above and beyond interindividual differences, a more general development in coping occurs throughout the life span. As adulthood can be described as shift in the balance of gains to losses, a constant change in the stressors and in the resources available to deal with these stressors characterizes the life span. When reaching advanced old age, individuals face unique challenges in terms of stressor quantity, as losses accumulate across all key domains of functioning, and in terms of quality, as many of these losses cannot be fixed. Specifically, very old adults experience declines in physical, functional, and cognitive health (e.g., multimorbidity, mobility, and sensory impairment;) and are further confronted with social (e.g., loss of children, relatives, and friends;) and psychological losses (e.g., loss of meaningful activities;). These age-related reductions in functional, social, and psychological resources not only constitute a stressor per se but also hamper implementation of strategies that would help deal with the stressor or compensate for loss.

When individuals can no longer actively solve problems because of the unchangeable nature of the stressors, resource restrictions, or reduced motivation for changing the situation, a shift in coping is to be expected to match the constraints and preserve well-being. For example, the dual-process model of coping describes that there will be a reduced preference for coping that focuses on solving the problem (i.e., assimilation) and increased preference for coping that aims at regulating emotions and cognitions (i.e., accommodation).

Brief Psychosocial Intervention

Psychoeducation is typically an ongoing process during treatment. Psychoeducation may occur while describing the process of psychotherapy, when inviting the mutual sharing of medical information (e.g., disease effects, prognosis, necessary medical intervention), and while validating key psychodynamic issues such as loss. Psychoeducation, the goal of which is to help people better understand (and become accustomed to living with) mental health conditions, is considered to be an essential aspect of all therapy programs. It is generally known that those who have a thorough understanding of the challenges they are facing as well as knowledge of personal coping ability, internal and external resources, and their own areas of strength are often better able to address difficulties, feel more in control of the condition(s), and have a greater internal capacity to work toward mental and emotional well-being.

MODELS OF PSYCHOEDUCATION

Information model - The focus is on providing families knowledge about psychiatric illness and their management.

Skill training model - The skill training model focusses on developing certain skills so that the family members can manage the illness more effectively.

Supportive model - The supportive model mainly involves taking help of support groups for engaging the family members of the patients in sharing their feelings.

Comprehensive model - The comprehensive model uses a combination of the previous three models.

Psychoeducation programs provide the information and skills needed by the elderly to assist them in maintaining physical, mental, social, and emotional health as they age.

Psycho-education is an educative method aimed to provide necessary information and training that promote physical, social, and emotional and independence in the elderly population for healthy aging. It is generally known that elderlies who have a thorough understanding of the challenges they are facing as well as knowledge of personal coping ability, internal and external resources, and their areas of strength are often better able to address difficulties, feel more in control of the condition(s), and have a better quality of life. Therefore, the need for psycho-educational programs, containing a combination of activities and balance training for enhancing the quality of life for elderlies. (Mohamed et al, 2022)

Activity scheduling (AS) has been established as a core component of evidenced-based treatment for depression with equivalent outcomes to cognitive behavioral therapy (Cuijpers et al 2007). Activity scheduling represents a key process in daily life, involving the evaluation of the costs and benefits of the resources to be invested, but also a preference for when to engage in pleasant or unpleasant activities. Activity scheduling can be an important tool, in addition to other treatment modalities, to help treat.

The principles of activity scheduling are – pleasure and mastery.

The scheduling process usually involves an evaluation of the costs and benefits of the resources to be invested, in terms of energy and time. Effective scheduling, in fact, includes a priority analysis of the activities to be carried out to achieve specific objectives. However, the selection of activities also depends on individual needs and subjective preferences on how to invest the time, that is, preferences on when to engage in pleasant, unpleasant, or neutral activities. Older adults are more motivated to collect and accumulate positive experiences, preferring activities and relationships that can ensure an improvement in mood and well-being in the present time. (La Malva et al., 2023)

Reminiscence therapy is defined by the American Psychological Association (APA) as "the use of life histories – written, oral, or both – to improve psychological well-being. The therapy is often used with older people." This form of therapeutic intervention respects the life and

experiences of the individual with the aim to help the patient maintain good mental health. The majority of research on reminiscence therapy has been done with the elderly community, especially those suffering from depression, although a few studies have looked at other elderly samples. Reminiscence has been described as “the volitional or non-volitional act or process of recollecting memories of oneself in the past”. There are different types of reminiscence which can take place. The two main subtypes are intrapersonal and interpersonal reminiscence. Intrapersonal takes a cognitive stance and occurs individually. Interpersonal takes more of a conversational side and is a group-based therapy. Reminiscence can then be further broken down into three specific types which are: information, evaluation, and obsessive. Information reminiscence is done to be able to enjoy the retelling of stories from one's past. This type can also be used to help someone who may be lacking interest in his or her life and relationships. The ability to recall good memories can help them remember what they do have to be happy about. Evaluative reminiscence is the main type of reminiscence therapy as it is based on Dr. Robert Butler's life review. This process involves recalling memories throughout one's entire life and sharing these stories with other people. Often this is done within group therapy. Obsessive reminiscence occurs when somebody needs to be able to let go of any stress of guilt that may be lingering. By working through these issues it allows them to be at peace with themselves. Reminiscence has also been used to help people deal with the death of a loved one. By sharing stories about the loved one's life they can remember fond memories and gain a sense of peace with the death.

Deep breathing exercise is a relaxation technique in which a person focuses on taking slow, deep breaths. Deep breathing involves breathing in slowly through the nose and then out through the mouth using the diaphragm (the thin muscle that separates the chest from the abdomen) and abdominal muscles. This helps boost the amount of oxygen in the blood, lowers blood pressure and heart rate, and reduces muscle tension. Deep breathing may be used to help relieve stress, pain, and anxiety. Also called abdominal breathing and diaphragmatic breathing. Scientific studies have shown that controlling breath can help to manage stress and stress-related conditions. Breath control is also used in practices such as yoga, tai chi and some forms of meditation. Many people use their breathing to help promote relaxation and reduce stress.

REVIEW OF LITERATURE

In Indian society, parents are majorly the responsibility of their son and not the daughter. Therefore, the sole responsibility of taking care of parents comes onto the shoulders of son and daughter-in-law (Jamuna, 1995). If they have loving bonds, then life becomes easier for the dependent parent. There is social stigma in Indian society against disclosing the internal family matters in public. That is why most of the time children take their parents for granted because they know that they will not say anything wrong about them in front of others. The changes in the traditional Indian norms related to the living arrangements and family constitution, wherein, older persons live with their children, specifically the son, has had an impact on the well-being of older persons. There is a general trend towards living in nuclear 75 families, whereby children live far away due to studies, work and personal preferences (Palloni, 2001). Besides living arrangements, housing conditions of older persons are a prominent research area, as everyday environment has a direct impact on the well-being of individuals (Knodel & Auh, 2002; Gaymu, 2003).

Dubey & Bhasin, et al. (2011) indicated that mostly elders who stay in old age homes feel that the attitude of younger is unsatisfied and as they no longer gives respect and love to their families Sharps & Prince-Sharps, et al. (1998). Willingly or unwillingly, many old age people now like to stay in old age homes instead of their own homes. They justify their decisions with the view that they feel lonely in their home; there is none to look after or talk to them. They have no freedom to take their friends at home and in many situations, they feel embarrassed but have none to listen to. Whereas, they get this type of freedom, care, and social support in old age homes. The pressurized conditions at home bring in them a feeling of disconnection, emotional hardiness to their family members and they feel comfortable in staying out of the family (Fahey & Montgomery, et al., 2003). This was the reason that senior citizens feel lonely among their family members and these conditions increase their problems in multiple. It is often seen that they are treated badly in their own homes, where they had been the head/owner of everything (Misra & Singh, et al. (2010). Thus, they have started to feel socially isolated and emotionally insecure within the boundaries of their own house, and sometimes they are just figured as no more than a symbol of frustration, stress, pity, sickness, and despair for their family members. Regarding socioeconomic status, Jones and his colleague (1984) suggested that the most common problem in senior citizens is depression but people are stigmatized to discuss such things and the conditions become worse in the case of higher socioeconomic families as well as in the condition of physical disability and financial stringency (Gjones & Tabassum, et al. 2009). In the present time, the priorities of the family members have changed

due to participation of women in financial activities and involvement of young children in computer, internet, and social media and outside of the home has reduced the quality of time being shared with old age people in the family. Nowadays, caregiving is a stressful task and affects the health of caregivers also; it can be more difficult when elders are fully dependent on them (Abd Allah, Mohammed, & Ahmed, 2017).

According to Netuveli and Blane (2008), subjective and objective variables are frequently used to describe the quality of life. The majority of older citizens rate their quality of life favourably when considering social ties, dependence, health, material circumstances, and societal comparisons. The maintenance and enhancement of quality of life must be among the objectives of clinical management. Payahoo, Pourghasem, and Jafarabadi (2014) reported that male elderly had a slightly higher score in the quality of life; however, these differences were not significant. They concluded that policies and programmes could be employed to better quality of life. Panday, Kiran, Srivastava, and Kumar (2015) examined and compared the QOL of senior residents of old age homes and those living in families. Two old age homes in Kantatoli and Kanke, Ranchi, were the locations of this cross-sectional study. There were 80 people in the sample (40 respondents from old age homes and 40 from family). The data was collected using tools like the QOL scale and the sociodemographic data sheet. The findings showed that older people's quality of life is higher in old age homes than it is for older persons living in family settings. According to Pereira, Nogueira, and Silva (2015), modern society has a strong desire for healthy ageing and a high quality of life. 372 senior citizens were chosen using proportionate stratified sampling. The majority of older people in the sample had a primary education that was only partially completed, were married, had a brown complexion, and were 60 to 69 years old. Although they indicated that their health and quality of life were satisfactory, the majority of them sought 1–3 medical interventions in the previous year and reported a high occurrence of cardiovascular, osteoporosis, diabetes, hypertension, and anxiety illnesses. The mean score for QOL was maximum in the psychological area and lowermost in the environmental domain.

According to Onunkwor et al. (2016), social support, long-term co-morbidities, gender, and outdoor recreational activities were all substantially related to all qualityof life dimensions. The physical domain of QOL scored the highest out of the four, while the social domain scored the lowest. Shah, Christian, Prajapati, Patel, and Sonaliya (2017) conducted community-based cross-sectional research among 250 senior citizens of Ahmedabad, Gujarat. The mean age of the sample was 65.8 years. Joint pain (42.8%), cataract (32.8%), hypertension (22.4%), diabetes mellitus (17.2%), and dental issues (12.4%) were the most prevalent morbidities seen

in them. This study revealed that none of the geriatric patients had poor QOL, whereas 56% fell into the good category and 50.8% had "excellent" QOL. QOL as per four different domains was significantly better among males as compared to females. Social characteristics like education, marital status, and gender play a role in the perceived QOL among the respondents. Seraji, Shojaeizadeh, and Goldoost (2017) studied the QOL of the senior citizens residing in Zahedan, Iran and reported that compared to men, women had significantly inferior life quality. Other demographic factors like age and education level did not demonstrate a significant correlation with QOL. Dasgupta, Pan, Paul, Bandopadhyay, and Mandal (2018) evaluated the quality of life and elements that affect it for the senior population living in the villages of Singur, West Bengal. Using simple random sampling, 146 elderly adults (60 years of age and over) were chosen for a community-based cross-sectional study. Data on sociodemographic traits and self-reported comorbidities were gathered using a validated Bengali version of the EQ-5D-3L (EuroQol) questionnaire. 54.1% of the 146 individuals had low QOL. A higher number of participants indicated issues with the dimensions of pain or discomfort and anxiety or depression. According to Menezes and Thomas (2018), the country's "older people" are being forced to reside in old age homes due to a quick increase in nuclear families and a remarkable increase in the number of older adults. Older people's needs, wants, and values are upheld in India's old-age homes. Younger generations can greatly benefit from the elderly; thus, society's attitudes regarding ageing need to alter. Kumari, Hemalatha, and Bhagyalakshmi (2019) studied a sample size of 100 elderly and found that 6% had poor quality of life, 34% had moderate quality of life, and 60% had high quality of life. Regarding life satisfaction, 47% had average and 53% had high satisfaction. There was a significant association between the quality of their lives and their education, occupation, health status, NGO programmes available to them, financial support, medical help, and government schemes. There was a positive correlation between quality of life and life satisfaction among senior citizens. Parsuraman, Vijayakumar, Eashwar, Dutta, Mohan, Jain, et al. (2021) studied the QOL among the elderly and the associated factors. This study was carried out in the urban area of Thiruvallur Dt., Tamil Nadu. 199 elderly people were selected by probability-proportionate sampling. It was seen that age and education were statistically and significantly correlated with all three QOL dimensions. It was noticed that gender and marital status were related to the psychological domain, whereas employment or pension status was related to the physical domain. According to Santora, Byrne, and Klockner's (2022) research, mental functioning was primarily related to one's perception of the meaning of life, along with one's health status, living situation, loneliness, neighbourhood quality, and level of satisfaction with one's income, and determined whether

one had a low, medium, or high quality of life. This study revealed that socio-demographic factors had no statistically significant effect on QOL.

Well-being may be defined as 'the striving for perfection that represents the realization of one's true potential' (Ryff, 1989, p. 100). However, well-being has been conceptualized in several forms. Ryan and Deci (2001) distinguished between two perspectives from which well-being can be understood: hedonic and eudaimonic. The former states that well-being consists of pleasure attainment and pain avoidance, and could be equated to happiness (Bradburn, 1969). The latter focuses on self-realization and meaning and conceptualizes well-being as the degree of functioning a person is capable of achieving (Ryff, 1989; Ryan and Deci, 2001; Waterman et al., 2010). Hedonic well-being has been traditionally associated to subjective well-being (SWB) (Keyes et al., 2002), while eudaimonic well-being has been identified as psychological well-being (Extremera et al., 2011). Subjective well-being, then, better accounts for the evaluation of one's life in terms of satisfaction and happiness. Psychological well-being, in turn, is best when referring to self-fulfillment and personal functioning.

Ryff (1989) compiled the theoretical conceptualizations of psychological well-being into six dimensions: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. These dimensions explain short-term well-being as well as more enduring life challenges that also constitute the sense of well-being. These dimensions can be measured with the Psychological Well-being Scales (Ryff, 1989; Ryff and Keyes, 1995), which represent one of the most widely used models of well-being (Tomás et al., 2012). However, there is a lack of consistency in the understanding of how these six dimensions articulate into a construct. While Ryff (1995) and Ryff and Keyes (1995) thought the six dimensions were indicators of a single construct of psychological well-being, Keyes et al. (2002) have more recently argued that there are strong associations among some of the six dimensions in Ryff's model with subjective well-being. Specifically, evidence shows a strong association between self-acceptance and environmental mastery (Keyes et al., 2002).

Ryan and Deci (2001) identified several potential antecedents of well-being, such as personality traits, emotions or social support. Some other authors have posed coping as one of the factors that can determine well-being (Cicognani, 2011; Por et al., 2011).

One particularly intensive study supports the finding of hedonic wellbeing improving with advancing age. Analyses of five momentary samples of affect (using the format 'how are you feeling right now?') per day recorded over seven days showed that the frequency of negative emotions decreased at middle age, although their intensity did not. (Carstensen LL, Pasupathi M et al., 2000)

Coping is defined as a set of cognitive and behavioral efforts that aim at managing the specific demands that exceed the resources of the individual (Lazarus and Folkman, 1984; Carver et al., 1989). The goal of coping strategies is to compensate or alleviate stressful situations by means of either the reformulation of objectives or the adjustment to a new and positively assessed situation (Gamrowska and Steuden, 2014). This compensation can be achieved by two means: emotion- and problem-focused coping strategies. Emotion-focused coping involves managing the emotional distress that is associated with a problematic situation (Lazarus and Folkman, 1984), this coping strategy involves individual's self-regulation aiming at minimizing emotional consequences of stressful situations (Schoenmakers et al., 2015). Problem-focused coping is centered toward modifying the problem at hand, and comprises individual actions undertaken to deal with stressful situations in order to change a situation that presents stress to the individual (Lazarus and Folkman, 1984; Schoenmakers et al., 2015). According to Folkman (1984), problem-focused coping strategies are more commonly implemented in situations in which the problem can be altered, and they help maintaining psychological well-being. Emotion-focused coping strategies, instead, are to be used when the problem is inalterable. Although, the distinction of emotion and problem-focused coping strategies is widely employed (Baker and Berenbaum, 2007; Dardas and Ahmad, 2015), it has also been argued that relying completely on these two general categories of coping strategies may hide important differences within categories, and also distorts the fact that these categories are not independent, with different coping strategies overlapping and facilitating each other (Folkman and Moskowitz, 2004). For example, seeking social support may be included in emotion- or problem-focused coping depending on its particular nature. For example, Schoenmakers et al. (2015) considered that improving relationships is a problem-focused way of coping and can be achieved by making new friends or re-establishing contact with old ones. Nevertheless, coping strategies can be related to well-being, by alleviating stressful situations. In this line, Tovel and Carmel (2014) have found a positive relation between coping strategies and measures of old people's subjective well-being. Tomás et al. (2012) also posed a relation among problem-coping, emotion-coping, and resilience coping, altogether predicting old adults' well-being. Phelan et al. (2004) identified coping as one of their four factors in their model of successful aging. Yet another study offered evidence of the role of problem- and emotion-focused coping strategies as predictors of well-being in a sample of young adults (Mayordomo-Rodríguez et al., 2015a). They found a positive direct effect of problem-solving coping and a negative effect of emotion-based coping on well-being. They also found that religion was not a relevant coping strategy, and that two coping strategies (problem-solving focus and avoidance) showed cross-

loadings in the two factors modeled (problem- and emotion-based coping). This model considered Ryff's six dimensions as indicators of a single well-being factor.

The need to establish the predictive power of coping strategies on well-being in old people is well endorsed by many theories of aging. For instance, the Selective Optimization with Compensation (SOC) model (Baltes and Baltes, 1990) or the Preventive and Corrective Proactivity (PCP) model (Kahana et al., 2014). The SOC model links well-being to coping strategies, as orchestrating processes that lead to outcomes such as loss minimization, growth, or well-being (Baltes and Baltes, 1990). The SOC model is essentially a model of problem-focused coping strategies, because selecting and optimizing goals and priorities, and trying to compensate for losses in energy and resources are all focused on direct actions (Wiese et al., 2000; Freund and Baltes, 2002). The PCP model states that older adults are very likely to face normative stressors such as chronic illnesses, social losses, and a lack of person–environment fit. The model also states that these stressors may be successfully handled with the use of internal and external resources. Among the internal resources, Kahana et al. (2014) stressed the importance of coping strategies, which are resources that can be translated into proactive behavioral adaptations (health promotion, helping others, planning ahead, marshaling support, or role substitution). When it comes to behavioral adaptations, it seems that problem-focused coping strategies would be more facilitators of behavioral change, as they imply problem-oriented actions, instead of self-regulation (Schoenmakers et al., 2015). These adaptations finally may exert an effect on quality of life and well-being. Therefore, the PCP model considers coping an internal resource directly linked to successful aging, as marked by well-being, and taking into account this approach, problem-focused strategies would be those to endorse for successful aging outcome. However, evidence points that older adults use more emotion-focused coping strategies, rather than problem-focused ones (Mayordomo-Rodríguez et al., 2015b; Chen et al., 2018).

All in all, literature points coping strategies both in general population and, specifically, in the older population. It has to be kept in mind that aging itself is a process of many changes, including not only physical, but also psychological and social changes (i.e., retirement, income decrease, or empty nest). As such, it is of paramount importance for older people to dispose of adequate strategies in order to minimize the emotional consequences of such stressful situations and adequate adapt to them (Schoenmakers et al., 2015). Because of that, the study of coping strategies can be the clue for the desired successful aging.

Although a considerable amount of research on adults' well-being and coping strategies has been published, not much regards the relationship between them (Tomás et al., 2012). Taking

into account aging of the population, scientific knowledge on determinants of old people's well-being could be a good starting point for the development of future interventions in this population. In Spain, for example, older population has grown in later years and it is expected to further grow in future years due to the fact that between 1957 and 1977, the so-called baby-boom generation took place, and this generation has currently started reaching retirement age (Serrano et al., 2014). Increasing aging of the population is also a fact for Europe in general (Długosz, 2011; Liotta et al., 2018). Indeed, the improvement of older people well-being through psychological variables that can be taught and learned in the old age, such as coping strategies, would enable the development of low-cost intervention programs and strategies.

In a study done by Rani and S (2021) it indicated that senior citizens staying in the old age home use more problem solving as compared to the senior citizens staying at their homes. This means that as much as the senior citizens get older and those staying in an old age home use problem solving coping strategies more often than home residents. The reason can be given that the senior citizens of old age home, have no resources and close relations to share their emotions and conflicts, so these conditions make them plan and execute before the problem reaches them, consequently, they remain active as compared to senior citizens staying in their homes (Dunar & Nordstom, 2005). In addition to it, they have been experienced struggle, troubles, and crises in the everyday life and keep on thinking that how to solve the problems and cope up with the challenges on the way of old age, but senior citizens staying in their homes are dependent on family members, they may not put many efforts to resolve the issues of life, instead, their family members take care of them or when family members do not take care of their issues, they experience neglect, rejection, and helplessness. The major part would be their acceptance that there is none to help them but subjects staying at their homes do not accept that family members never accept this fact that children will not help. A study indicated that older adults are more problem-focused than adults because they have passed so many years with stressful life events and their solutions (Blanchard & Mienaltowski et al., 2007).

Problems to be Investigated

In this study the applicability of the Brief Psychosocial Intervention Package which will include Depression Psychoeducation Program in the Elderly, Activity Scheduling, Reminiscence Therapy, Deep Breathing Exercise on the elderlies residing in old age facilities to enhance their quality of life, coping strategies and wellbeing will be investigated. Additionally, an analysis will be conducted to see how the elderly individuals receiving the Brief Psychosocial Intervention Package are progressing in comparison to those who are not.

METHODOLOGY

AIM:

The aim of the study is to evaluate the applicability of Brief Psychosocial Intervention Package which will include Depression Psychoeducation Program in the elderly, Activity Scheduling, Reminiscence Therapy, Deep Breathing Exercise in the context of Quality of Life, Coping Strategies and Wellbeing of the elderlies residing in old age facilities.

OBJECTIVES:

- To assess the applicability of Brief Psychosocial Intervention Package on quality of life of the elderlies residing in old age facilities.
- To assess the applicability of Brief Psychosocial Intervention Package on coping strategies of the elderlies residing in old age facilities.
- To assess the applicability of Brief Psychosocial Intervention Package on the well-being of the elderlies residing in old age facilities.
- To assess the sustainability of gain of Brief Psychosocial Intervention Package on quality of life of the elderlies residing in old age facilities.
- To assess the sustainability of gain of Brief Psychosocial Intervention Package on coping strategies of the elderlies residing in old age facilities.
- To assess the sustainability of gain of Brief Psychosocial Intervention Package on the well-being of the elderlies residing in old age facilities.

FORMULATION OF HYPOTHESIS:

- There will be no significant difference in quality of life between control group and experimental group in pre and post assessment.
- There will be no significant difference in quality of life between control group and experimental group in pre assessment, post assessment and follow-up assessment.
- There will be no significant difference in coping strategies between control group and experimental group in pre and post assessment.
- There will be no significant difference in coping strategies between control group and experimental group in pre assessment, post assessment and follow-up assessment.
- There will be no significant difference in wellbeing between control group and experimental group in pre and post assessment.
- There will be no significant difference in wellbeing between control group and experimental group in pre assessment, post assessment and follow-up assessment.

RESEARCH DESIGN:

This study is a prospective and comparative study. The subjects will be selected for the study on a consecutive basis, using the purposive sampling technique.

VENUE OF THE STUDY:

Old age facilities preferably in Ranchi or nearby areas.

SAMPLE:

The sample for the study will include 20 elderly people living in old age facilities, in the age range of 60 to 75 years. The sample will be divided into 2 groups (control group and experimental group), of 10 elderlies in each group.

Experimental group will be given structured sessions of Brief Psychosocial Intervention Package, and on the other hand Control group will go through their normal routine activities only.

INCLUSION CRITERIA:

- Elderlies living in old age facilities for at least 1 year or above.
- Age range between 60 to 75.
- Both male and female elderlies
- Participants who will give informed consent to participate in the study.

EXCLUSION CRITERIA:

- Elderlies having any physical and neurological illness
- Not coming under the age range of 60 to 75.
- Elderlies living in old age facilities for less than 1 year.
- Destitute elderly people.

TOOLS:

- Socio-Demographic data sheet
- Beck Depression Inventory (Beck, 1996)
- WHO Quality of Life Scale (WHOQOL-BREF) (Saxena et al, 1998)
- Way of Coping Questionnaire (Lazarus & Folkman, 1985)
- Psychological General Well-Being Schedule (Dupuy,1984)
- Rosenberg Self- Esteem scale (Rosenberg, 1965)
- Brief Psychosocial Intervention Package

Socio-Demographic Data Sheet

A semi-structured Performa will be especially designed to obtain information about socio-demographic variables like age, sex, education, marital status, religion, family type etc.

Beck Depression Inventory (Beck, 1996)

The Beck Depression Inventory (BDI) is a 21-item, self-report rating inventory that measures characteristic attitudes and symptoms of depression (Beck, et al., 1961). The Beck Depression Inventory (BDI, BDI-1A, BDI-II), created by Aaron T. Beck, is a 21-question multiple-choice self-report inventory, one of the most widely used psychometric tests for measuring the severity of depression. Each item is scored 0 to 3 points for a total score range of 0 to 63. The scale was developed as a quantitative measure of depression and was not originally intended as a diagnostic instrument (Kendall, Hollon, Beck, Hammen, & Ingram, 1987). Suggested score ranges for mild depression, moderate to severe depression, and severe depression are 10–19, 20–30, and 31 or higher, respectively (Kendall et al., 1987). The questionnaire was developed from clinical observations of attitudes and symptoms occurring frequently in depressed psychiatric patients and infrequently in non-depressed psychiatric patients. Twenty-one items were consolidated from those observations and ranked 0–3 for severity. The questionnaire is commonly self-administered although initially designed to be administered by trained interviewers. Self-administration takes 5–10min. The recall period for the BDI-II is 2 weeks for (major depressive symptoms) as operationalized in the fourth edition of *Diagnostic and Statistical Manual* (DSM-IV).

WHOQOL – BREF (Saxena et al, 1998)

The WHOQOL – BREF, an abbreviated version of WHOQOL – 100 QOL assessment, is a self-administered questionnaire. It measures individual's perception of their life with respect to their goals, expectations, standards and concerns and the culture and value system they live in. The WHOQOL- BREF is composed of 24 items combined into 4 broad domains rated on a 5point scale: physical health, psychological well-being, social relationships and environment. The WHOQOL – BREF is recognized as displaying good discriminate validity, internal consistency, and test-retest reliability.

Way of Coping Questionnaire (Lazarus and Folkman, 1985)

The scale was developed by Lazarus and Folkman in 1985. The way of coping questionnaire assesses thoughts and actions individuals use to cope with the stressful encounters of everyday living. The scale has already been used in many researches. The way of coping questionnaire

could potentially be used as a stimulus for discussion in clinical, training and workshop settings. It has 66 items which have 8 areas. Each item has 4 points (0-3). Description of the 8 areas are following: 1) Confronting coping, 2) Distancing, 3) Self controlling, 4) Seeking social support, 5) Accepting responsibility, 6) Escape avoidance 7) Planful problem solving, 8) Positive re-appraisal. There are two methods of scoring – raw and relative. Raw score describes coping effort for each of the 8 type of coping, where as relative scores describe the proportion of effort represented by each type of coping. In both methods of scoring, individuals respond to each item on a 4 point Likert scale, indicating the frequency with which each strategy is used: 0 indicate does not apply, 1 indicate to score the way of coping questionnaire, add the raw score of each item on the scale to get a total score. Raw score describe the coping effort for each of the 8 type of coping. High score indicate that the person often used the behaviors described by that scale in coping stressful events. It has been reported to have good reliability as well as convergent and predictive validity. Test-retest reliability for the Way of coping questionnaire has been reported to be 0.90.

Psychological General Well-being Schedule (Dupuy, 1984)

This scale was developed by H. J. Dupuy (1984). To measure a person's subjective well-being. It is a self – reported questionnaire and it has 22 items which have six areas. Each item has 6 points (0-5) scales. Scores for each affective group = SUM (points assigned for each question in group) where: the number in square brackets represent the points assigned for selected answer. Higher score indicate good psychological general well being in the each domain. The reliability or internal consistency of the good psychological general well being is 0.9 and each dimension scored between 0.56 and 0.88.

Affective group	**Questions**	**Range of scores**
Anxiety	5, 8, 17, 19, 22	0-25
Depressed mood	3, 7, 11	0-15
Positive well-being	1, 9, 15, 20	0-20
Self-control	4, 14, 18	0-15
General health	2, 10, 13	0-15
Vitality	6, 12, 16, 21	0-20

Rosenberg Self- Esteem Scale (Rosenberg, 1965)

The purpose of the 10 item RSE scale is to measure self-esteem. Originally the measure was designed to measure the self-esteem of high school students. However, since its

development, the scale has been used with a variety of groups including adults, with norms available for many of those groups. Rosenberg Self Esteem scale scoring involves a method of combined ratings. Low self-esteem responses are “disagree” or “strongly disagree” on items 1, 3, 4, 7, 10, and “strongly agree” or “agree” on items 2, 5, 6, 8, 9. Two or three out of three correct responses to items 3, 7, and 9 are scored as one item. One or two out of two correct responses for items 4 and 5 are considered as a single item; items 1,8, and 10 are scored as individual items; and combined correct responses (one or two out of two) to items 2 and 6 are considered to be a single item. The scale can also be scored by totaling the individual 4 point items after reverse-scoring the negatively worded items.

Brief Psychosocial Intervention Package

A Psychosocial intervention package will be given to the 10 elderlies of experimental group. The psychosocial intervention package will be consisting of the followings: -

- Psychoeducation
- Activity Scheduling
- Reminiscence therapy
- Deep Breathing exercise

Psychoeducation –

Depression Psychoeducation Program in the elderly will be used in the study which is based on the Colorado Model of Psychoeducation. It will psycho-educate the elderlies and also give them moral support.

The Colorado model was developed by American family foundation for Post-Traumatic Stress Disorder, Acute Stress, Adjustment Problem, Sexual Harassment, Mental and Physical torture, People with disaster affected for recovery and empower them for their psychological problems. It comprises 10-12 sessions and duration of each session is 45 minutes. Stages of Colorado Model:

1. **Establish safety:** overview of cult recovery, critical thinking and PTSD and triggers.
2. **Remembrance and mourning:** Anger and grief, inventing and reinventing yourself. (Through mapping techniques.)
3. **Reconnection:** Boundaries, recognition, repair, relationship and intimacy.

This model has two tracks: 1. Psychoeducation and moral support.

2. Recovery issues.

In a study done by Nurhidayati et al. (2022) she used the 13-step psychoeducation on elderlies. The results show that the psychoeducational intervention program has been effective in increasing self-esteem, increasing family knowledge, attitudes, and behavior in caring for the elderly, and then reducing the level of depression and loneliness. The 13-step psychoeducation program is known as Depression Psychoeducation Program in the elderly. The psychoeducation program consists of following 13 steps.

1) Health education regarding: Personal Hygiene; 2) Information on measures to enhance immunity and management; 3) How to maintain daily routine; 4) How to stay healthy, pleasant activities, social skills; 5) Health education about Sleep hygiene; 6) Self-esteem 7) Role of physical activity and diet on stress management 8) Pain management 9) Breathing exercises 10) Depression-problem solving, behavioral activation, and cognitive-behavioral perspective on depression; 11) Acidity management 12) Management of Hyper tension 13) Side effects of self-medication.

As we know Psychoeducation programs provide the information and skills needed by the elderly to assist them in maintaining physical, mental, social, and emotional health as they age, the 13-step psychoeducational intervention will be provided to the geriatric population living in the old age homes.

Activity Scheduling –

Activity scheduling is an established component of evidenced-based treatment for late-life depression in primary care. Activity scheduling is a behavioral treatment for depression first described by Lewinsohn et. al. (1969) in a case study demonstrating the benefits of positive reinforcement gained from an increase in social engagement and rewarding activities.

Activity scheduling (AS) has been established as a core component of evidenced-based treatment for depression with equivalent outcomes to cognitive behavioral therapy (Cuijpers et al 2007). One of the most appealing aspects of activity scheduling as a component of treatment for depression is its relatively straightforward nature, which makes it easy for patients to understand and easy to deliver by health care workers who are not mental health specialists. Little is known from efficacy studies of AS about the nature of the activities discussed in treatment, relationships between different activities and their relative impact on depression outcomes. (Riebe et al., 2012)

Activity scheduling will be decided on the priority analysis of the activities to be carried out to achieve specific objectives. However, the selection of activities will also depend on individual

needs and subjective preferences on how to invest the time, that is, preferences on when to engage in pleasant, unpleasant, or neutral activities.

Reminiscence Therapy –

Reminiscence therapy improves older adults' remission of depression and quality of life shortly after the session.

Reminiscence therapy (RT) is a type of psychotherapy that involves recalling past events. By returning to these past incidents, people feel pleasure. Often employed with older people, this type of life review therapy improves a person's sense of well-being. Dr. Robert Butler, a psychiatrist who worked in the area of geriatric medicine in the 1960s, is credited with first exploring the therapeutic value of reminiscence. Because RT is a non-pharmacological form of intervention, it can be widely used.

Reminiscence sessions may be conducted in a formal or informal way, either one-on-one or in a group setting. The American Psychological Association states that the use of reminiscences or life histories can take place in either written or oral formats.

Instrumental reminiscence therapy helps the elderly recollect past coping activities and strategies, including memories of plans developed to solve difficult situations, goal-directed activities, and the achievement of one's own goals or goals one helped others meet. Instrumental reminiscence therapy may exert a positive effect on individuals' self-esteem and efficacy by recollection of successful experiences in which individuals acted effectively to control their environment. This approach to reminiscence therapy puts roles and commitments that are no longer rewarding or attainable to the periphery and helps these patients invest in other goals that are more in tune with current conditions of living. This can be especially helpful for the elderly who may not be able to do what they were once capable of doing.

Many studies have examined the effects of reminiscence therapy on overall affect. One group of researchers implemented reminiscence therapy into a community in response to a rash of suicides. The researchers administered the therapy to older adults (predominantly women) at a local community center for the elderly. A questionnaire administered after the group reminiscence therapy session revealed that 97.3% of participants enjoyed the experience of talking, 98.7% enjoyed listening to others, 89.2% felt that the group work with reminiscence therapy would help in their daily life, and 92.6% wished to continue in the program. The researchers suggest their results support the previously reported effects of increased life satisfaction and self-esteem. Another study showed that after one session a week for 12 weeks of integrative reminiscence therapy, institutionalized older veterans in Taiwan experienced

significant increases in self-esteem and life satisfaction as compared to the control group. However, there is some evidence that RT can improve quality of life, cognition, communication and possibly mood in people with dementia in some circumstances, although all the benefits were small. A Cochrane review (2018) concluded that reminiscence therapy can improve quality of life, cognition, communication and possibly mood in people with dementia in some circumstances, although all the benefits were small. A few researchers have posited that the positive effects of reminiscence therapy are the result of increased coping skills. (Cappeliez et al, 2010).

In this study, for Reminiscence Therapy, the researcher will play nostalgic songs from the elders' early adult years. In addition, the elders will participate in various activities such as exchanging humorous anecdotes, writing poetry or stories, and sharing recipes, all of which will help the elders regain their positive outlook.

Deep Breathing Exercise –

Deep breathing exercise is a relaxation technique in which a person focuses on taking slow, deep breaths. Deep breathing involves breathing in slowly through the nose and then out through the mouth using the diaphragm (the thin muscle that separates the chest from the abdomen) and abdominal muscles.

This helps boost the amount of oxygen in the blood, lowers blood pressure and heart rate, and reduces muscle tension. Deep breathing may be used to help relieve stress, pain, and anxiety.

Deep Breathing Exercise can help Anxiety, Depression, Managing Stress, Improving Focus, Better Sleep and PTSD.

Deep Breathing Exercise offers many mental health benefits for people. It can enhance Social Connectedness, Positive Emotions and Mindfulness Benefits.

There are two phases of breathing: inhaling (taking breath in) and exhaling (breathing out). When we inhale, the diaphragm — which is the big, dome-shaped muscle located between your chest and abdominal cavities — contracts and moves downward. This creates extra space in the chest cavity, and the lungs expand into it. When we exhale, the diaphragm relaxes as the amount of air in the lungs is reduced. Breathing is essential to life because our bodies require oxygen to function; moving the muscles, digesting food, and even reading these words are all body processes that require oxygen. Breathing also helps the body get rid of carbon dioxide, which is created as a waste product of these processes.

World Health Organization recommends various types of Deep Breathing Exercises, Pursed Lip Breathing, Breathe Focus Technique, Alternate Nostril Breathing, Diaphragmatic

Breathing (Abdominal Breathing), 4-7-8 Breathing, Equal Breathing etc. For the Brief Psychosocial Intervention Package, Diaphragmatic Breathing exercise and 4-7-8 Breathing exercise would be chosen.

Diaphragmatic Breathing (Abdominal Breathing) exercise:

- Sit or lie down in a comfortable position.
- Place one hand on your chest and the other on your abdomen.
- Inhale slowly through your nose, allowing your abdomen to rise as you fill your lungs with air.
- Exhale slowly through your mouth, letting go of tension as your abdomen falls.
- Focus on the rise and fall of your abdomen rather than chest movement.

4-7-8 Breathing exercise:

- Sit or lie down comfortably.
- Close your eyes and take a deep breath in, through your nose for a count of 4.
- Hold your breath for a count of 7.
- Exhale completely through your mouth for a count of 8.
- Repeat this cycle several times, gradually increasing the duration as you become more comfortable.

Procedure

Step – 1

Conveniently selecting old age facilities, elderlies will be selected from the facilities for the study on a consecutive basis, using the purposive sampling technique

→ Selection of elderlies will be done according to the inclusion and exclusion criteria.

→ 20 elderlies will be selected, in which 10 elderlies will be selected for control group and 10 elderlies will be selected for experimental group.

Step-2 (Pre-assessment)

Socio- demographic data sheet, Beck depression inventory, WHO Quality of Life Questionnaire (WHOQOL – BREF), Way of coping questionnaire, Psychological general well-being schedule, Rosenberg self- esteem scale will be applied on 20 elderlies (10 elderlies in control group and 10 elderlies in experimental group).

Step-3 (Intervention)

The Brief Psychosocial Intervention Package will be given to 10 elderlies of experimental group, in a group setting.

10 elderlies of Control group will go through their normal daily routine activities only.

Step-4 (Post-assessment)

For Post Assessment Beck depression inventory, WHO Quality of Life Questionnaire (WHOQOL – BREF), Way of coping questionnaire, Psychological general well-being schedule, Rosenberg self- esteem scale will be re-applied on 20 elderlies (10 elderlies in control group and 10 elderlies in experimental group), to see the applicability of the Brief Psychosocial Intervention Package.

Step – 5 (Follow up)

For Follow up, after 1 month of interval the tools of the study will be applied on 10 elderlies in experimental group, to see the sustainability gain of the Brief Psychosocial Intervention Package.

For Ethical Consideration, after the study is done, the Brief Psychosocial Intervention Package will be applied on the control group

Statistical analysis

Using the Statistical Package for Social Science (SPSS), the pre- and post-assessment data will be computed and compared to determine whether the Brief Psychosocial Intervention Package is applicable to the experimental group. Similarly, the data gathered for the post-assessment and follow-up will be computed. The results will be compared to determine the sustainability gain of the Brief Psychosocial Intervention Package.

Ethical considerations in research are a set of principles that guide the research designs and practices. These principles include voluntary participation, informed consent, anonymity, confidentiality, potential for harm, and results communication.

Scientific integrity, respect for human rights and dignity, and cooperation between science and society all depend on research ethics. These guidelines ensure that study volunteers are safe, informed, and willing to participate in investigations.

Scientists and researchers must always adhere to a certain code of conduct when collecting data from others.

These considerations protect the rights of research participants, enhance research validity, and maintain scientific integrity.

BRIEF PSYCHOSOCIAL INTERVENTION PACKAGE

The brief psychosocial intervention package will have **30 sessions**, it will be applied in a group setting. The Brief Psychosocial Intervention Package will be consisting of Psychoeducation which will include Depression Psychoeducation Program in the elderly, Activity Scheduling, Reminiscence therapy, Deep Breathing exercise.

Session No: 1 **Formulating a group** Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To build rapport and establish trust and respect among group members	• Self-introduction: group members were encouraged to introduce themselves to others in group and to the researcher.	Creating a group, who will be interested to receive the brief psychosocial intervention package

Session No: 2 **Group Work Engagement** Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To deal with shyness, uncertainty and diffidence among the members	• Facilitating of group unity and we feeling through empathetic relationship building. • Encouraging helping and help seeking behavior.	Established empathetic relationship in the group

Session No: 3 **Orientation of Group members** Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To orient the group goals and objectives	• Discussion on group norms, goals, and potential benefits of group intervention.	Creating a goal-oriented group, who will be interested to receive the brief psychosocial intervention package

Session No: 4 **Explanation about Intervention Package** Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To explain about the potential benefit about the brief psychosocial intervention package to the group	• Discussion on brief psychosocial intervention package, and potential benefits of group intervention.	Creating a group, who will be interested to receive the brief psychosocial intervention package

Session No: 5 **Starting the brief psychosocial intervention package**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Help the members to understand about their health • Learning about maintaining personal hygiene	• They will be enlightened about psychoeducation • First step of the psychoeducation program will be given 1) Health education regarding: Personal hygiene.	Improvement in the elderly's knowledge about importance of health, personal hygiene, and gaining information on how to manage those.

Session No: 6 **Briefing them about immunity**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Learning the information on enhancing immunity and managing health	• Second step of the psychoeducation program will be given 2) Information on measures to enhance immunity and management	Improvement in the elderly's knowledge about importance of immunity and gaining information on how to manage those.

Session No: 7 **Maintaining daily routine**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Help the members to understand about the importance of maintaining daily routine	• Third, step of the psychoeducation program will be given: 3) How to maintain daily routine	The elderlies learning about maintaining a proper daily routine

Session No: 8 **Staying healthy**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Help the members to understand about the importance of staying healthy.	• Fourth step of the psychoeducation program will be given: 4) How to stay healthy, pleasant activities, social skills.	The elderlies maintaining a proper daily routine, so they can stay healthy, get engaged in pleasant activities, get socialized.

Session No: 9 **Sleep hygiene**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Learning sleep hygiene techniques	• Fifth step of the psychoeducation program will be given: 5) Health education about Sleep hygiene	The elderlies maintaining a proper daily routine, so they can stay healthy, get engaged in pleasant activities, get socialized, and have a proper sleep hygiene.

Session No:10 **Initiating activity schedule**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Learning about making activity schedules	• Discussion on activity scheduling: the elderlies will be advised and encouraged to make their own activity schedule.	The elderlies understanding the importance of making their own daily activity schedule.

Session No:11 **Assembling Activity Schedule**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Creating activity schedule.	• Elderlies assembling activities. Selection of activities will depend on individual needs and subjective preferences on how to invest the time, that is, preferences on when to engage in pleasant, unpleasant, or neutral activities. • Previously learned sleep hygiene, social skills, ways of staying healthy will also be included in the activity schedule.	The elderlies maintaining a proper daily activity routine, so they can stay healthy, also monitoring how they are following the activity schedule.

Session No:12 **Maintaining Activity Schedule**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Following the activity schedules	• The elderlies will be advised and encouraged to follow their own activity schedule.	The elderlies maintaining a proper daily activity routine, so they can stay healthy, also monitoring how they are following the activity schedule.

Session No: 13 **Self - esteem**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To learn about self esteem	• Sixth step of the psychoeducation program will be given: 6) Self-esteem	Elderlies gaining knowledge about self-esteem.

Session No: 14 **Physical activity and Diet**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To understand the importance of physical activity and diet • Learning about stress management	• Seventh step of the psychoeducation program will be given: 7) Role of physical activity and diet on stress management	Elderlies gaining knowledge about self-esteem, learning about role of physical activity and diet on stress management which will be helpful in their daily life, which will help them in stress management, and slowly it will help them to strengthen their self- esteem.

Session No:15 **Monitoring Activity Schedule**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Following the activity schedules	• The elderlies will be advised and encouraged to follow their own activity schedule. • They will also be encouraged to add some light physical activity in their daily activity schedule, and also to maintain diet daily.	The elderlies maintaining a proper daily activity routine, so they can stay healthy, manage stress. Also monitoring how they are following the activity schedule.

Session No:16 **Pain Management**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To learn about pain management	• Eighth step of the psychoeducation program will be given: 8) Pain management	The elderlies learning the importance of pain management and how that will help their health.

Session No:17 **Breathing exercises**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To learn about breathing exercise.	• Ninth step of the psychoeducation program will be given: 9) Breathing exercises	The elderlies learning the importance of deep breathing and how that will help their health.

Session No:18 & 19 **Learning Deep breathing exercise**

Duration: 30 to 35 minutes

Objectives	**Content**	**Expected Outcome**
• To teach deep breathing exercise	• Introducing Deep breathing exercise (Diaphragmatic Breathing and 4-7-8 Breathing). (Daily 5 - 10 minutes)	They will keep practicing deep breathing and keep following the activity schedule, while also maintaining what they learning from the psychoeducation program.

Session No:20 **Problem solving** Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To learn problem solving, behavioral activation, and cognitive-behavioral perspective on depression.	• Tenth step of the psychoeducation program will be given: 10) Depression-problem solving, behavioral activation, and cognitive-behavioral perspective on depression.	Improving knowledge about depression-problem solving, behavioral activation, and cognitive-behavioral perspective on depression.

Session No:21 **Managing Health** Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To learn acidity management.	• Eleventh step of the psychoeducation program will be given11) Acidity management	Improving knowledge about acidity management.

Session No:22 **Hyper tension**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To learn management of hyper tension.	• Twelfth step of the psychoeducation program will be given: 12) Management of Hyper tension.	Improving knowledge about management of hyper tension.

Session No:23 **Self- medication, side effects**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To learn side effects of self-medication.	• Thirteenth step of the psychoeducation program will be given: 13) Side effects of self-medication.	Improving knowledge about side effects of self-medication.

Session No:24 **Introduction of Reminiscence therapy**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Introducing reminiscence therapy on the elderlies	• Reminiscence therapy will be done on the elderlies. the researcher will play nostalgic songs from the elders' early adult years which will help the elderlies regain their positive memory.	Reminiscence therapy will help the elderly recollect past coping activities and strategies, including memories of plans developed to solve difficult situations, goal-directed activities.

Session No:25 & 26 **Reminiscence therapy**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• To do reminiscence therapy on the elderlies	• Reminiscence therapy will be done on the elderlies • The elders will participate in various activities such as exchanging humorous anecdotes, writing poetry or stories, and sharing recipes, all of which will help the elders regain their positive outlook.	Reminiscence therapy will help the elderly recollect past coping activities and strategies, including memories of plans developed to solve difficult situations, goal-directed activities.

Session No:27 **Monitoring the Brief Psychosocial Intervention Package**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• If the elderlies of the experimental group are following the Brief Psychosocial Intervention Package properly.	• Monitoring if the elderlies of the experimental group are following the Brief Psychosocial Intervention Package properly.	The elderlies of the experimental group are following the Brief Psychosocial Intervention Package properly.

Session No:28 **Initiating the termination of the group**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Letting the elderly know that the group therapy is coming to an end.	• Preparation of ending group • Discussion on learning experiences and achievement of group goals	Elderlies understand and agree to the termination of group therapy.

Session No: 29 **Feedback from Group Members**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Getting feedback from the group members	• Feedback from members for their perceived benefits for attending the group sessions	Honest feedback from the group members

Session No:30 **Termination of the Brief Psychosocial Intervention**

Duration: 40 to 45 minutes

Objectives	**Content**	**Expected Outcome**
• Termination of the group	• Encouraging group members to continue supporting relationship and continue using the skills they learned from the intervention.	Evaluation of group goals and objectives achieved

Significance of the Study

Old age is the closing period of the life span, old age is being associated with deterioration of all physical, psychological factors, isolation from social, economic, and other activities. Socially, this stage was considered as the sum total of one's lived experiences. Care home or old age home is a home environment primarily for those elderly persons who are unable to stay with family members due to various reasons. Older adults living in old age homes face problems of adjustment with tight and rigid schedules; total or near-total separation from their family, friends and society; anxiety over entrusting oneself to a new environment; diminished physical ability and close and frequent encounters with death and ailments in the institution. For many of them social support is almost absent and this leaves older adults with the feeling that he or she does not belong, is not loved or cared for, esteemed or valued. For these reasons the brief psychosocial intervention will be given to the elderlies residing in old age facilities to evaluate its applicability on enhancing quality of life, coping strategies and wellbeing of the elderlies residing in old age facilities.

Contribution of the study

The study will contribute for the elderlies residing in old age facilities. As Older adults living in old age homes face problems of adjustment with tight and rigid schedules; total or near-total separation from their family, friends and society; anxiety over entrusting oneself to a new environment; diminished physical ability and close and frequent encounters with death and ailments in the institution. For many of them social support is almost absent and this leaves older adults with the feeling that he or she does not belong, is not loved or cared for, esteemed or valued. For these reasons the brief psychosocial intervention will be given to the elderlies residing in old age facilities to evaluate its applicability on enhancing quality of life, coping strategies and wellbeing of the elderlies residing in old age facilities.

Future work

Future study can be planned with randomized control design to establish the findings at larger extent. The Brief psychosocial intervention package can be developed to use appropriately among elderlies living in old age facilities. For future study the study venue can be expanded. The Brief psychosocial intervention package can be applied on a large sample size. Additional therapies and activities can be included in the Brief psychosocial intervention package such as supportive therapy, extra-curricular activities.

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Note: This synopsis is tentative, which may be modified or changed based on the availability of cases, tools, techniques and other situations.